HANDBOOK
Ohio County Commissioners
Published by: County Commissioners Association of Ohio

209 East State Street • Columbus, Ohio 43215-4309
Phone: 614-221-5627 • Fax: 614-221-6986 • www.ccao.org

CHAPTER 67

HEALTH INSURANCE

Latest Revision
July 2013
Note: Some provisions in this Chapter become effective 9-29-13

67.01 INTRODUCTION

Most Ohio counties provide some form of health insurance for their elected officials and employees. This benefit is provided to improve employee morale, to help attract and retain employees, and is popular with employees because it is a form of compensation that is not taxable. The levels of coverage vary greatly from county to county as does the amount the employee contributes to provide the coverage. It should be stressed that the provision of health insurance by the county is not statutorily required. In other instances the provision of health care coverage and the level of benefits are subjects of collective bargaining agreements.

This Chapter will discuss some of the options available to counties to provide health benefits to employees. This Chapter will also detail the legal authorities contained in the Ohio Revised Code concerning health insurance and procedures required to purchase conventional or "fully insured" products or to set up self-insured programs. It will also generally discuss the use of what is commonly referred to as cafeteria plans, flexible benefits, and consumer driven health plans such as Health Savings Accounts (HSA's) and Health Reimbursement Accounts (HRA's). There are many ways to provide health benefits that can be both cost effective and still provide employees with comprehensive and complete coverage.

Two of the common concerns of many county commissioners are the constantly increasing cost of providing health coverage to employees and employee expectations of the coverage available to them. Cost containment is one of the keys to having affordable health care coverage. While this sounds simple, it is a very complex problem. There is generally reluctance on the part of employees to accept changes or restrictions to their benefit program. Employees need to understand that deductible changes and increases in employee contributions will only temporarily fix the problem. What needs to be done is that employees need to invest in their own health and wellness. An overall health and wellness program contains several key parts starting with the support of county commissioners and other elected officials and employee ownership of their own health and wellness and becoming a better informed consumer.

Innovative and imaginative approaches need to be used to educate and convince employees of the positive aspects of cost containment. Some of the more common approaches in use today are wellness programs, health fairs, managed care programs, employee health insurance committees, the use of preferred provider organizations (PPO's), Health Savings Accounts, Flexible Spending Accounts and numerous other techniques such as training and educational programs provided by various state and national health organizations and societies.

67.011 ROLE OF THE STATE RELATING TO HEALTH INSURANCE FOR COUNTY EMPLOYEES

Recent state legislation has included provisions that provide a role for the Department of Administrative Services (DAS) in health care plans provided to public employees by political subdivisions, including counties. DAS has established the Public Employee Health Care Plan Program within the Department and has authority to hire staff as necessary to provide administrative support to the program.

ORC Section 9.901 provides that: "All health care benefits provided to persons employed by employers as defined by this section shall be provided by health care plans that contain best practices established by the former School Employees Health Care Board or the Department of Administrative Services. All policies or contracts for health care benefits that are issued or renewed after the expiration of any applicable collective bargaining agreement must contain all best practices established pursuant to this section at the time of renewal."

This relatively new law takes effect on September 29, 2013. In addition, the law provides for a modification of this provision of law as follows: "Upon consulting with the Department of Administrative Services, a political subdivision may adopt a delivery system of benefits that is not in accordance with the Department's adopted best practices if it is considered by the Department to be most financially advantageous to the political subdivision."

Under this same law DAS has the following responsibilities:

1. Identify strategies to manage health care costs;

2. Study the potential benefits of state or regional consortiums of public employers' health care plans;

3. Publish information regarding the health care plans offered by political subdivisions, public school districts, state institutions, and existing consortiums;

4. Assist in the design of health care plans for political subdivisions, public school districts, and state institutions of higher education;

5. Adopt and release a set of standards that shall be considered the best practices for health care plans offered to employees of political subdivisions, public school districts, and state institutions, and to adopt rules for the enforcement of health plan sponsors' compliance with the best practices standards adopted by DAS;

6. Require that plans the health plan sponsors administer make readily available to the public all cost and design elements of the plan;

7. Promote cooperation among all organizations affected by this section in identifying the elements for successful implementation of this section;

8. Promote cost containment measures aligned with patient, plan, and provider management strategies in developing and managing health care plans; and

9. Prepare and disseminate to the public an annual report on the status of health plan sponsors' effectiveness in complying with best practices and making progress to reduce the rate of increase in insurance premiums and employee out-of-pocket expenses, as well as progress in improving the health status of employees and their families.

In addition, the DAS Director may convene a Public Health Care Advisory Committee. The committee would make recommendations on the development and adoption of best practices. The committee consists of fifteen members: five members appointed by the speaker of the house of representatives; five members appointed by the president of the senate; and five members appointed by the Governor and must include representatives from state and local government employers, state and local government employees, insurance agents, health insurance companies, and joint purchasing arrangements currently in existence.

67.02 RELATIONSHIP TO PROHIBITED IN-TERM PAY CHANGES FOR COUNTY OFFICERS

Health insurance provided to county officers is a form of compensation (*State ex rel. Parsons v. Ferguson,* 46 Ohio St. 2d 389 and OAG 84-058). As such it is subject to the

Constitutional prohibition against in-term compensation changes under Article II, Section 20 of the Ohio Constitution which reads:

> "The general assembly, in cases not provided for in this constitution, shall fix the term of office and the compensation of all officers; but no change therein shall affect the salary of any officer during his existing term, unless the office is abolished."

County officers are allowed to receive benefits when they take office. As a general rule, insurance coverage and payments cannot change after a county officer has taken office as such changes are considered a change in compensation during a term of office which is prohibited by the Constitution.

A county officer includes elected or appointed officers who are identified as those individuals who exercise a portion of the state's sovereign authority and have the power and discretion to make an act or decision without being accountable to anyone else.

While it is clear that the constitutional prohibition against in-term compensation changes applies to the county line officers, the term "county officer" is much broader and may extend to appointed county officials whose duties and responsibilities meet the test of exercising sovereign authority. Note that judges are exempt from this provision under the "Modern Courts" amendment to the Constitution.

In addition, ORC Section 3501.12, which provides for the compensation for the board of elections members, expressly provides that "For the purposes of this section, members of boards of elections shall be deemed to be appointed and not elected, and therefore not subject to Section 20 of Article II of the Ohio Constitution."

This provision of law was enacted in 1984 (Am. Sub. HB 897) and appears to be contrary to previous rulings of the Ohio Supreme Court, however, the Attorney General in Opinion 1997-027 stated that until there is a judicial opinion to the contrary, that the amendment should be presumed to be constitutional.

Specifically, this Opinion states that: "Ultimately, therefore, whether the above-quoted language added to R.C. 3501.12 by Am. Sub. HB 897 altered the Ohio Supreme Court's conclusion that board of elections members are subject to the prohibition of Ohio Const. art. II, § 20 is a matter that must be determined by the judiciary. Within the scope of an opinion, this office is, therefore, obliged to presume the constitutionality of R.C. 3501.12, and must advise you to follow the mandates of R.C. 3501.12, as most recently amended in Am. Sub. HB 408. At the same time, however, we must also caution you of the potential constitutional conflicts that exist within the statute. *See generally City of Rocky River v. State Employment Relations Bd.,* 43 Ohio St. 3d 1, 6, 539 N.E.2d 103, 108 (1989) ("it is generally beyond the power of the legislature to change or 'correct' judicial interpretation of the Constitution... The doctrine of judicial supremacy in constitutional interpretation is widely and generally conceded"); *State ex rel. Shkurti v. Withrow,* 32 Ohio St. 3d 424, 429, 513 N.E.2d 1332, 1337 (1987) ("the interpretation of the Ohio Constitution is ... not a legislative but a judicial question, which ultimately this

court must decide"). For additional information related to health insurance for Board of Elections members refer to Section 67.18.

The rapidly changing nature of health insurance cost and plans continues to challenge the circumstances under which the county, or any political subdivision for that matter, may alter a pre-existing plan in-term for its public officers without violating this constitutional provision. The most recent discussion of this issue is presented in OAG Opinion 2012-024.

The test for determining whether a prohibited in-term change in compensation or salary has occurred is whether the number of public dollars paid on behalf of the officer has changed. This was further refined in *Schultz v. Garrett,* 6 Ohio St. 3d 132 (1983) to address those situations in which an officer's compensation had been established at the commencement of a term pursuant to a formula where the Court concluded at page 135, as follows:

> "When a statute setting forth the formula for the compensation of an officer is effective before the commencement of the officer's term, any salary increase which results from a change in one of the factors used by the statute to calculate the compensation is payable to the officer. Such increase is not in conflict with Section 20, Article II of the Constitution when paid to the office while in term. Section 20, Article II of the Constitution forbids the granting of in-term salary increases to officers when such changes are the result of direct legislative action on the section(s) of the Revised Code which are the basis of the officers' salaries."

The Attorney General in a series of opinions, most recently in OAG 2012-024 at page 5, has set out the test to be applied to answer this question:

> "The test for determining whether a prohibited in-term change in compensation has occurred is whether there has been a change in the number of public dollars expended on behalf of a public officer during the officer's term, with the exception that, in those situations in which a public officer's compensation or a component thereof was fixed at the commencement of the officer's term pursuant to a formula, a change in compensation that occurs as a result of a non-legislative change in one of the external factors used in that formula is not prohibited by the Constitution."

This test is a question of fact and is answered by determining, first, was the health care benefit portion of compensation fixed at the beginning of the official's term pursuant to a formula (i.e., the options that were available to the officer at the commencement of the term of office), and, second, if so, whether the current increase in the dollar amount expended for the official has occurred as a result of a non-legislative change in one of the external factors used in such formula. Consequently, the focus is upon the change in the number of county dollars spent on the officer's behalf for such benefits, and whether such change results from a direct legislative change to the terms upon which the county made such benefits available to the official at the commencement of the official's term. If the change occurs and can be traced back to the operation of a "formula" in place at the time the officer took office then an in-term change has not taken place and the constitutional provision has not been violated.

While this general rule sounds fairly simple, the actual application of the rule is much more complex depending on the nature of the change in coverage, cost, premium, and deductibles and how the change is implemented in a county. Because the extension of health insurance benefits to county elected officials and other county officers has not been the subject of any recent litigation the Attorney General has very little case law to rely upon when inquiries are made for opinions regarding this subject.

The Attorney General has provided advice to counties in OAG 2005-031 in an attempt to assist them with the structuring of a resolution adopted by the commissioners in which they outline their county's health care options for their officers and employees. The opinion, on page 9, notes that:

> "It is the commissioners resolution authorizing benefits under ORC 305.171 that establishes the health care benefits available to county personnel and determines the choices that are available to a county officer at the commencement of his term. The language of the resolution in effect at the commencement of an officer's term also determines whether such choices are offered pursuant to a formula. In the event the county's health care options are made available pursuant to a formula, the resolution also establishes the elements of such formula. The resolution setting forth the county's health care options … (is) the reference point for determining whether a mid-term change in an officer's health benefits has occurred, and whether such change is prohibited by Ohio Const. Art. II, Sec. 20."

The question is: Was the change in coverage to a level of coverage and percentage of premium that was available to the officer at the commencement of a term? And because such a significant emphasis is placed upon the "formula" used to determine health care benefits, the challenge is to draft the provisions of the resolution defining the "formula" to help answer this question.

One possible approach is to adopt a resolution that includes a provision indicating that the elected officials, during a term of office, are entitled to the same benefits generally provided to county employees because it is possible that such benefits and options available to county employees at the commencement of an elected officials or officers' term may from time to time be altered, adjusted, or eliminated. This includes changes in premiums, deductibles, fixed copays, copays expressed as a percent, coinsurance amounts, out-of-pocket maximums, and annual plan maximums related to the coverage and/or design of medical, prescription drug, dental and vision plans. It further includes modifications to the plan design itself that either increases or decreases the specific items covered or the extent to which an item may be covered. When adopting such a resolution advice from the county prosecutor is vital.

67.03 POPULAR HEALTH INSURANCE OPTIONS

Counties have four primary options to provide health benefits to elected officials, officers, and employees. County finances, the amount and type of risk the county is willing to assume, and the availability of proper insurance coverage, are some of the determining factors. Subsequent sections of this Chapter will discuss the legal authorities and requirements for the following primary health insurance options:

1. CONVENTIONAL INSURANCE - The county purchases an insurance policy covering elected officials, officers, and employees to cover the entire risk. This type of insurance is commonly referred to as “fully insured” because the county pays a fixed premium and all other risk is assumed by the insurance company irrespective of the cost of claims filed during a contract period. Included in this option is the possible provision of services through a health maintenance organization (HMO) or a preferred provider organization (PPO). Conventional insurance may be the easiest to administer, but depending on the size and loss experience of the county, there may be more financially viable alternatives.

2. INDIVIDUAL SELF-INSURANCE PLAN - The county establishes a special fund in the county treasury and maintains an actuarially sound reserve in this fund. Claims up to a specified level are paid from the fund and the county purchases "stop loss" coverage to protect this reserve fund. Counties may purchase either individual or aggregate stop loss coverage to protect the county for claims that exceed the amounts reserved in the special fund. Individual stop loss insurance covers claims above a certain predetermined amount for each employee, while aggregate stop loss insurance covers the county when the total amount of claims paid from the special fund in any year exceeds the amount of the reserved funds for the year. Counties may contract for the administration of such a plan with an insurance company or a third party administrator. (Ohio Attorney General Opinion 84-066).

3. JOINT SELF-INSURANCE PLAN – The county may join with other political subdivisions in providing a joint self-insurance program and may share risk with the other political subdivisions up to the amount specified in a joint agreement. Funds must be reserved using actuarial principles, and this option involves the creation of a separate legal entity which is usually a non-profit corporation or a regional council of governments. The legal entity often contracts for the administration of such a plan. This option also allows political subdivisions to join together to jointly purchase conventional health insurance. The County Commissioners’ Association of Ohio established and staffs a service program that is a joint self-insurance pool in this category, the County Employee Benefit Consortium of Ohio (CEBCO).

4. HSA/HRA – Health Savings Accounts and Health Reimbursement Accounts have gained in popularity in recent years and are common types of what is referred to as consumer driven health plans. These programs are newly available as of January 1, 2004 as a result of an amendment to ORC Section 9.833 (B)(2). The HSA must be maintained in accordance with Section 223 of the Internal Revenue Code, and the county may pay for or fund federally qualified High Deductible Health Plans that are linked to HSA’s or make contributions to HSA’s. An HSA or an HRA may be provided as part of a self-insurance program.

   HSA programs pairs a High Deductible Health Plan with a savings account to help pay for qualified medical expenses. Health Savings Accounts are the most

popular with employees. These programs combine the pre-tax treatment of a health flexible spending account, the portability and carry-over characteristics of a 401(k) plan, and the tax-free distribution of a Roth IRA. HSA's are owned by the individual and used to pay for qualified medical expenses. Both the county and employee can fund the account and the account is fully portable. Earnings on account balances accrue tax deferred and can be carried over year to year. The HSA is held by a custodian or trustee.

An HRA differs from an HSA in that the funds remain the county's funds, only the county can fund the account; there is no portability, and no catch up contributions are allowed, which are permitted under an HSA.

Attorney General Opinion 2007-032 allows townships to establish an HRA. The opinion states that ORC Section 9.833 does not preclude a township from setting up the HRA, but the opinion also states that the resolution must establish the program at the beginning of the trustees term in office and not during the term in office, which is a constitutionally prohibited in-term compensation change. This opinion allowing for HRA's probably also applies to counties.

Finally, more counties are developing what is commonly referred to as cafeteria plans or flexible benefits. In addition to providing a more flexible package of benefits for the use of employees based on differing needs, such programs also can save money for counties and provide additional tax benefits to employees. These plans are authorized by Section 125 of the Internal Revenue Code, and are further explained in Section 67.16.

67.04 GROUP INSURANCE COVERAGE

County commissioners may, pursuant to ORC Section 305.171, contract, purchase, or otherwise procure and pay for all or any part of the cost of group insurance policies that may provide benefits to elected officials, officers, employees, and their immediate dependents including:

1. Group insurance policies that may provide any of the following:

    a. Benefits including, but not limited to, hospitalization, surgical care, major medical care, disability, dental care, eye care, medical care, hearing aids, or prescription drugs;

    b. Sickness and accident insurance;

    c. Group legal services;

    d. Group life insurance.

2. Any other qualified benefit available under Section 125 of the "Internal Revenue Code of 1986," 26 U.S.C. 125.

3. A health and wellness benefit program through which the county provides a benefit or incentive to county officers, employees, and their immediate dependents to maintain a healthy lifestyle, including, but not limited to, programs to encourage healthy eating and nutrition, exercise and physical activity, weight control or the elimination of obesity, and cessation of smoking or alcohol use.

4. Any combination of any of the foregoing types of insurance, coverage, or benefits.

Generally, the board of county commissioners is the contracting authority for most county elected officials, officers and departments. Other county elected officials do not have the authority to contract for health insurance even though it is considered as compensation under the law. One possible exception, which will be discussed later, is the board of elections. Also, while in some counties boards like Developmental Disability Boards and Children Services Boards participate in county health insurance programs, each has its own independent authority to contract and procure their own health insurance.

It appears Employee Assistance Programs (EAP's) are also authorized under this statute because of the nature of the coverage provided. An EAP provides counseling services, legal services and other services that are authorized in ORC Section 305.171(A). Since EAP's provide benefits that include a combination of the foregoing types of insurance or coverage issued by an insurance company from the funds or budgets from which the county officers or employees are compensated, EAP's are authorized for county elected officials, officers, and employees and their dependents.

In addition to providing coverage through an insurance company, county commissioners can also contract for plans of group insurance and health care services with health care corporations (ORC Chapter 1751) if the following conditions are met:

1. Each elected official, officer, or employee has the option to participate in such an alternative plan offered by the health insuring corporation.

2. If such a plan costs more than the regular county program, the participant must personally pay the difference.

3. Each participant has the right to change from one of the plans to the other plan each year at a time determined by the commissioners.

ORC Section 305.171(E) also authorizes counties to provide the benefits through an individual self-insurance program or a joint self-insurance program as provided for in ORC Section 9.833. A county may use any of these options in combination.

Prior to the enactment of ORC Section 9.833 the Attorney General ruled that this section authorized counties to contract for "minimum premium plans" where a county pays claims up to a specified level and an insurance company pays claims in excess of the amount the county pays itself (OAG 81-069) A county could also hire employees to administer such a plan or may contract with an insurance company or third party administrator to administer such a program (OAG 84-066). These plans will be discussed in greater detail later in this Chapter; however the use of the term “minimum premium plan” was essentially the same as individual county self-insurance programs that are now specifically authorized in ORC Section 9.833.

67.05 JOINTLY ADMINISTERED HEALTH AND WELFARE BENEFIT TRUSTS

Counties may agree to participate in a jointly administered health and welfare trust fund to provide health benefits to certain county employees. Such trusts are established under the terms of a collective bargaining agreement. Under such an agreement, which is exempt from competitive bidding and the request for proposal procedure of ORC Section 307.86, all benefits or specific benefits may be provided by self-insurance. The benefits must be authorized by the rules of the board of trustees of the jointly administered health and welfare trust fund. The same benefits may be provided to employees under a trust as may be provided above for employees, and the board of trustees of the trust may require contributions from employees to the trust fund (ORC 305.17(C)(D) and 124.81).

67.06 INDIVIDUAL AND JOINT SELF-INSURANCE PROGRAMS

Counties are authorized to establish and maintain either individual or joint self-insurance programs (ORC 305.17(E) and 9.833). A county may use any one or any combination of the following options:

1. Maintain an individual self-insurance program to provide benefits.

2. Maintain a health savings account program in accordance with Section 223 of the Internal Revenue Code which may be a part of a self-insurance program.

3. After establishing an individual self-insurance program, join with other political subdivisions, including municipalities, townships, other counties, and other governmental entities within the state, to have its self-insurance program jointly administered as specified in an agreement.

4. Join in any combination with other political subdivisions to establish a joint self-insurance program under terms specified in a written agreement.

5. Join with any combination with other political subdivisions to procure or contract for policies, contracts, or plans of insurance to provide health care benefits, which may include a health savings account program for their elected officials, officers and employees, under terms specified in a written agreement.

6. Purchase plans containing best practices established by the Department of Administrative Services under ORC Section 9.901.

7. A joint self-insurance program is not an insurance company, is not subject to insurance laws, and is exempt from state and local taxes.

It should be stressed that the individual and joint self-insurance programs authorized under ORC Section 9.833 must reserve funds in a special fund, conduct actuarial reporting, evaluation of funds reserved, and financial reports which must be maintained for public inspection. This requirement, however, does not apply to municipal individual self-insurance programs, but does apply in all cases to other political subdivisions, including counties.

67.061 COVERAGE AVAILABLE TO NONPROFIT CORPORATIONS REPRESENTING THE INTERESTS OF POLITICAL SUBDIVISIONS

An individual or joint self-insurance program contract awarded to a nonprofit corporation or a regional council of governments may provide that all employees of the nonprofit corporation or regional council of governments, the employees of all entities related to the nonprofit corporation or regional council of governments, and the employees of other nonprofit corporations that have 50 or fewer employees and have been organized primarily to represent the interests of political subdivisions, may be covered by the under the terms and conditions set forth in the contract.

67.07 REQUIREMENTS FOR INDIVIDUAL AND JOINT SELF INSURANCE PROGRAMS (ORC 9.833(C))

Reserve and reporting requirements apply to both individual and joint self-insurance programs of counties established pursuant to ORC Section 9.833.

Funds must be reserved as are necessary, in the exercise of sound and prudent actuarial judgment, to cover potential cost of health care benefits for the elected officials, officers and employees of the political subdivision.

A joint self-insurance program is required to pay for the run-off expenses of participating political subdivisions that terminate participation in the program if the political subdivision has accumulated funds in the reserves for incurred but not reported claims. This run-off payment requirement is limited to an actuarially determined cap or 60 days, whichever is reached first. This provision of law, which became effective September 29, 2013, however, does not apply during the term of a specific, separate agreement with a political subdivision to maintain enrollment for a period of not more than three years. (ORC 9.833(C)(11)).

An annual report must be prepared no later than March 1 of each year, or 90 days after the end of the program year. This report is to be maintained in the office of the program administrator. The report:

1. Must include the aggregate of disbursements made for:

    a. Program administration costs.

    b. Aggregate claims paid.

    c. Legal representation.

    d. Consultant fees.

2. Must include a certified audited financial statement along with a written report from a member of the American Academy of Actuaries certifying that the amounts reserved:

    a. Conform to the requirements of ORC 9.833(C).

    b. Are computed in accordance with accepted loss reserving standards.

    c. Are fairly stated in accordance with sound loss reserving principles.

3. Must be available for inspection by any person at all reasonable times during regular business hours, and, upon the request of such person, shall make copies of the report available at cost within a reasonable period of time.

4. The program administrator shall also provide the annual report to the State Auditor.

5. Is in lieu of any public records requested under ORC Section 149.431(A).

Joint self-insurance pools like CEBCO are audited each year by the State Auditor. The reserve funds and the applicable requirements are subject to review during these audits. The requirements for self-insurance reserve funds are outlined in AOS Bulletin 2001-05 which are available at:

http://www.auditor.state.oh.us/services/lgs/bulletins/2001/2001-005.pdf

ORC Section 5705.13 allows for the establishment of a reserve balance account either in the general fund or as an internal service fund for an individual self-insurance program.

67.08 PROGRAM ADMINISTRATION

A county that utilizes any of the four primary options authorized by ORC Section 9.833 usually contracts for the administration of the program. Division (C)(3) of this Section authorizes such a contract with any private company, political subdivision, non-profit corporation or a regional council of governments. These contracts do not require competitive bidding as long as there has been full, prior public disclosure of all terms and conditions. These contracts do require a written evaluation of reserve funds under Division (C)(1) of this Section, by a member of the American Academy of Actuaries.

In the case of a joint self-insurance program a normal procedure is for the subdivisions forming the joint program to establish a legal entity which is usually a non-profit corporation or a regional council of governments to be the legal entity for developing and administering the program. This entity then may contract for day-to-day administrative services and claims processing.

67.09 ALLOCATION OF COSTS TO FUNDS

A county that has an individual self-insurance program or that participates in a joint self-insurance program may allocate the costs of coverage among accounts or funds in the county treasury on the basis of relative exposure and loss experience (ORC 9.833(C)(2) and (5)). The allocation of costs is usually calculated on a per employee basis based on actual employee counts of the departments that are a part of the program. Costs that are allocated are usually on a tier structure that represents the census of the county, and the costs that are assigned to that tier. Monies are either billed back to the various departments for payment or allocated internally as a part of the appropriation resolution.

67.10 ASSUMPTION OF RISK OF OTHER POLITICAL SUBDIVISIONS

Under a joint self-insurance program a county may assume risks of other political subdivisions who are members of the program. The assumption of the risk of other subdivisions, however, must be specified in a written agreement and is limited to the extent detailed in the agreement (ORC 9.833(C)(8)).

67.11 ISSUANCE OF DEBT TO PAY CLAIMS AND ESTABLISH RESERVES

Counties are authorized to issue general or special obligation bonds that are not payable from real or personal property taxes for purposes related to health insurance as follows:

1. To provide funds to pay expenses associated with settling claims.

2. To provide funds for a county that establishes an individual self-insurance program to establish a special fund from which to pay claims.

3. To provide funds to pay the county costs, including the establishment of a reserve fund, for establishing and maintaining a joint self-insurance program.

These bonds need not follow normal issuance procedures as set forth in the uniform bond law unless the county elects to use these procedures. In such a case, bonds may be issued for not more than 20 years. Such bonds are exempt from the direct debt limit of ORC Sections 133.04-133.07, but are subject to the indirect or constitutional debt limit.

67.12 COMPETITIVE BIDDING EXEMPTIONS

The purchase of conventional health insurance is exempt from normal competitive bidding requirements. In place of competitive bidding, for conventional health insurance coverage, the following procedures apply:

1. The county must determine that compliance with the regular competitive bidding requirements required by ORC Section 307.86 would increase, rather than decrease costs.

2. The county can purchase coverage by issuing a request for proposal. Under the RFP, the county would purchase from the proposal that provides the most comprehensive package at the most competitive price.

3. The county can negotiate with insurers for the purpose of purchasing the insurance coverage at the best and lowest price reasonably possible.

Advertising, notice, and bid bond requirements normally applicable to regular competitive bidding do not apply to the purchase of health insurance. In place of notice requirements, an insurance company or agent may submit their name and address to the county who must establish a special notification list to which it must send the request for a health insurance proposal.

When submitting the request for a health insurance proposal to agents or brokers on the special notification list the county must:

1. Include in the request for a health insurance proposal the deadline and place for submitting the proposal.

2. Submit the request for a health insurance proposal to the agents or brokers at least six weeks before the deadline for submitting proposals.

3. Request proposals and re-negotiate the health insurance contract at least every three years from the date of execution of the contract.

The county may review the special notification list every five years and may remove the name of any agent or broker from the list, but must mail notice of the removal of the name from the list to the agent or broker.

As it relates to an individual self-insurance program, counties need not comply with either competitive bidding or the request for insurance proposal procedure outlined above when contracting for administration of the program. Bidding requirements for individual and joint self-insurance plans are discussed further in Section 67.14.

In the case of a joint self-insurance program, a county that wants to join such a program must enter into a contract with a separate legal entity that could include a private company, a non-profit corporation, or a regional council of governments.

Before such a contract is executed for an individual self-insurance program or before the county becomes a member of a joint program, however, full public disclosure of the terms and conditions of the contract must be made. The contract cannot be entered into without full, prior, public disclosure of all terms and conditions. The disclosure should include a statement listing all representations made in connection with any possible savings and losses resulting from the contract, and potential liability of any political subdivision or employee. The proposed contract and statement has to be disclosed and presented at a meeting of the county commissioners not less than one week prior to the meeting when the county commissioners sign the contract or authorizes its execution. (ORC 9.833(C)(3)).

Under this provision of law, the non-profit corporation or regional council of governments can also insure the employees of the COG or the non-profit. Employees of related entities can also be so insured and of other non-profits if they have 50 or fewer employees and are organized primarily to represent the interests of political subdivisions.

Finally, for counties who participate in jointly administered health and welfare trusts neither competitive bidding or the request for a health insurance proposal apply to the establishment of such a trust or to the provision of benefits. In addition, refer to Section 67.13 of this Chapter for further information about the history and relevant opinions of the Attorney General concerning individual and joint self-insurance plans.

67.13 HISTORY OF STATUTES/RELEVANT ATTORNEY GENERAL'S OPINIONS CONCERNING "MINIMUM PREMIUM PLANS" AND INDIVIDUAL AND JOINT SELF-INSURANCE PLANS

Remembering that a county government’s powers are limited to those provided by statute, ORC Section 305.171 specifically authorizes a county to provide group insurance for its employees. There are basically three ways in which a county may procure this coverage.

First, the county may choose to follow the general competitive bidding process for goods and services set out at ORC Sections 307.86 to 307.92. This process includes provisions found in ORC Section 307.88 that could require that a bid would have to be accompanied by a bid or performance bond.

Second, with respect to the procurement of health insurance the county is given the statutory option to elect to follow the provisions of ORC Section 307.86 (F) and thereby exempt itself from the competitive bidding process and use the RFP process described in Section 67.12.

Finally, the county is authorized pursuant to ORC Section 305.171 (E) to obtain the health insurance coverage through an individual self-insurance program or a joint self-insurance program authorized by ORC Section 9.833. This section provides that a political subdivision (i.e. a county) may provide health care benefits in various ways including through a written agreement with a joint self-insurance program which may be awarded to a nonprofit corporation without the necessity of competitive bidding under ORC Section 9.833(C)(3).

The County Employee Benefits Consortium of Ohio (CEBCO) is organized under Ohio law as a nonprofit corporation and administers a joint self-insurance program providing health care benefits for county governments.

Consequently, a board of county commissioners may contract with CEBCO to provide a health insurance program for its employees without participating in the bidding process. This conclusion is further supported by Ohio Attorney General Opinion 91-044 which found: “the provisions of R.C. 9.833(C)(3) appear to offer the county the convenience of contracting for the administration of its self-insurance program with specific entities without requiring competitive bidding…”

There is some confusion about the procedures that must be used to develop individual or joint self-insurance programs, and requirements to procure insurance or administrative services in conjunction with such programs. In order to understand the legal requirements it is necessary to analyze ORC Sections 305.171 and 9.833 and Attorney General's Opinions 81-069, 84-066, 91-044, and 91-048.

Prior to the enactment of ORC Section 9.833 in 1991 (HB 737, effective 4/11/91) there was no authority to truly self-insure. Various counties had, however, provided coverage under what was commonly referred to as "minimum premium plans" which the Attorney General ruled were authorized by ORC Section 305.171.

Under the "minimum premium plan", counties would provide that the county itself would pay claims up to a specified amount and above the specified amount an insurance company would pay the claims (OAG 81-069). Essentially, under such a program the county would purchase either individual or aggregate "stop loss" coverage to pay claims above a certain amount for any employee or above a predetermined amount for the entire county during any policy year. The “minimum premium plan” language is not one

that is used in the health insurance industry, but is being used in this Chapter to explain past rulings.

The Attorney General had previously ruled (OAG 81-045) that school districts could provide these types of "minimum premium plans" and ruled that counties had the same authority. This opinion also implied that the county could contract with an insurance company providing the "stop loss" coverage to perform administrative services in conjunction with "minimum premium plans".

Later the Attorney General ruled that the county could hire employees to administer a "minimum premium plan" in house and could also contract with either an insurance company not providing the "stop loss" coverage or with another entity such as a third party administrator to administer the plan (OAG 84-066).

After the enactment of ORC Section 9.833, the Attorney General issued two additional opinions on matters related to "minimum premium plans" authorized pursuant to ORC Section 305.171 and relating to the new authority to self-insure by providing either individual or joint self-insurance programs under ORC Section 9.833.

In OAG 91-044, the Attorney General expanded on previous opinions by stressing that the purchase of insurance benefits is different from the purchase of services to administer the insurance program whether they are developed pursuant to either ORC Section 305.171 or 9.833.

The Attorney General further stated that the purchase of benefits under either section is exempt from competitive bidding. The purchase of services to administer the plan, however, is different. If the plan is a "minimum premium plan" authorized under ORC Section 305.171, competitive bidding of administrative services is required. A county may authorize, under ORC Section 9.833(C)(3), non-competitive bid contracts only to those entities listed in this Section. County commissioners may contract with any entity other than those enumerated in ORC Section 9.833(C)(3) as long as it complies with the competitive bidding requirement of ORC Section 307.86.

Later in the same year the Attorney General, issued OAG Opinion number 91-048. Here the Attorney General ruled that the purchase of insurance, including "minimum premium plans" developed under ORC Section 305.171 are exempt from competitive bidding if they comply with ORC Section 307.86(F).

Finally, this opinion (OAG 91-048) ruled that when a county contracts for administrative services pursuant to either section (305.171 or 9.833), that commissioners cannot authorize the purchase of coverage beyond the limits of the county's self-funded plan from a third party administrator which has been awarded an administrative contract.

Much of the reasoning in these opinions is difficult to follow. It should be stressed that when the legislation enacting ORC Section 9.833 was passed by the General Assembly it was "last minute" legislation and did not carefully look at the implications to ORC

Section 305.171. Counties are thus encouraged to consult with legal counsel for proper advice when entering into contracts for developing an individual self-insurance program, or when forming or joining joint self-insurance program. Under the old law, the Attorney General refers to “minimum premium plans”, but the new law refers to individual or joint self-insurance plans or contracts. The term “minimum premium plan” is an outdated terminology that is no longer used in the industry today.

67.14 JOINT HEALTH CARE COST CONTAINMENT PROGRAMS

In order to keep the cost of conventional insurance at the lowest cost possible and to assure the success of individual or joint self-insurance programs, cost containment is critical. Counties are authorized to establish joint health care cost containment programs with any combination of other political subdivisions under ORC Section 9.833(C)(7).

The purpose of such a program is to prevent and reduce health care costs. In this regard the joint cost containment program may employ risk managers, health care cost containment specialists and other consultants.

67.15 SECTION 125 PLANS/CAFETERIA PLANS/FLEXIBLE BENEFITS

When a board of county commissioners offers any of the benefits authorized under ORC Section 305.171 (See Section 67.04 above) to an elected official, officer, or employee, the board may offer the benefits through a cafeteria plan meeting the requirements of Section 125 of the Internal Revenue Code.

Under such an agreement, which usually compliments a basic health insurance program, premium contributions made by employees is deducted from gross compensation for tax purposes. This usually results in greater take-home-pay, and less tax liability. These arrangements often include either a cafeteria plan and/or a flexible spending account.

Under a cafeteria plan, employees may choose various benefits that are offered by the county employer on a pre-tax basis. This often includes the ability to purchase other insurance such as long term care insurance, cancer insurance, accident insurance, and disability insurance which the employee may purchase with personal funds through payroll deduction. This provides the opportunity to purchase these supplemental benefits on a pre-tax basis, and allows the employee to pay less in taxes and have additional dollars in their paycheck.

A flexible spending account is an arrangement that provides employees the choice of having money deducted from their compensation on a pre-tax basis to pay for out-of-pocket expenses for medical benefits not covered by a basic health insurance program. Such an arrangement may also allow for the payment of child care on a pre-tax basis. The development of these arrangements can benefit the employee and can contain or reduce county costs.

67.16 CASH PAYMENTS IN LIEU OF COVERAGE (ORC 305.171)

The county commissioners can adopt a policy authorizing county appointing authorities to make a cash payment to county employees, elected officials, and officers who waive insurance coverage. The payment cannot exceed 25% of what would otherwise be paid in premiums. Counties should be careful in considering such plans to cost out the likely savings. This is true particularly in counties with substantial employee contributions toward insurance premiums and where those who can drop coverage may have already done so. The county could find itself paying a bonus to individuals who have already dropped coverage without encouraging many more to do so. Counties should note that these payments are taxable income to the participants. Employers also should require employees to certify in writing that they have other insurance coverage in order to qualify for the payment.

Under the law the option for a cash payment must be done under a cafeteria plan under Section 125 of the Internal Revenue Code. The cash payment can be in any form permissible under the cafeteria plan.

67.17 HEALTH INSURANCE COMMITTEES

A number of counties have established a Health Insurance Committee to help review and strategize on the various benefit plans available to county governments. The committee's feedback can provide crucial information commissioners can utilize when making a health care decision. Health care dollars are one of the largest costs and emotionally charged decisions a commissioner can make. Successful Health Insurance Committees provide a forum where employee's views can be shared with commissioners. Commissioners should establish parameters for the committee and boundaries of their duties, however, it should be clearly understood that the Health Insurance Committee is not responsible for making the final decision on health insurance issues. A Health Insurance Committee can also focus on wellness initiatives and promote a team work approach to bringing about reasonable change in the health insurance plan provided to the county.

67.18 BOARD OF ELECTIONS HEALTH INSURANCE

ORC Section 3501.141(A) authorizes the board of elections to contract, purchase or otherwise procure and pay all or any part of the cost of group insurance policies that may provide benefits for hospitalization, surgical care, major medical care, disability, dental care, eye care, medical care, hearing aids, and prescription drugs. It also provides for sickness and accident insurance, group life insurance, or a combination of any of the foregoing types of insurance or coverage for the full time employees and their immediate dependents. It should be noted that the board of elections, unlike other county entities, has the authority to contract for coverage different from that offered to other county employees or for types of coverage not provided to other county employees, but only if the commissioners have, by resolution, denied full time employees of the board of elections the coverage.

Under ORC Section 3501.141(B) the board of elections, with the approval of the board of county commissioners, also has the authority to obtain group health insurance for themselves and their immediate dependents when the members' term begins. In the case of the board of elections, it appears that the eligible types of insurance are limited to group hospitalization, surgical, major medical, or sickness and accident insurance or a combination of any of these foregoing types of insurance or coverage.

It was generally thought that members of a board of elections were also subject to the prohibition against in-term compensation changes for health insurance as required by Article II, Section 20 of the Constitution. However, in 1984 the General Assembly enacted Am. Sub. H.B. 897 which stated that for the purposes of ORC Section 3501.12 (the provision of law that established compensation, but not health benefits for board of elections members) "members of boards of elections shall be deemed to be appointed and not elected, and therefore not subject to Section 20 of Article II of the Ohio Constitution." Later, in 1997, in OAG Opinion 97-027 the Attorney General concluded that this statute should be presumed to be constitutional until a contrary judicial opinion was rendered, and no such opinion has been rendered to date.

It should be noted that ORC Section 3501.141(B) was changed in 2005 to make the provision of health insurance for members of the board of elections subject to approval by the board of county commissioners. Prior to that time, the board of elections had the authority to make this determination itself.

The statute provides that the insurance must be provided at the beginning of a term of office. Thus, if members of the board of elections are authorized by the commissioners to have health insurance at the beginning of a term of office they are eligible to enroll. If a member of the board of elections chooses not to enroll at the beginning of a term in office, and later determines that they want to enroll, they may not do so because the statute limits the eligibility to the beginning of a term of office.

Thus, if the members of the board of elections had been receiving insurance benefits that were established by the board of elections prior to the time the law was amended to provide authority to the county commissioners, and the commissioners want to eliminate this coverage, they can do so by not approving the board of elections procurement or payment of insurance benefits (See ORC 3501.141(B). But, such a change cannot take effect to eliminate officers' health insurance benefits in the middle of a term of office.

OAG Opinion 97-027 considers the question of whether health insurance can be eliminated in the middle of a term. The opinion concludes and CCAO believes that, since the provision of ORC Section 3501.12 limiting the applications of Article II, Section 20 only applies to compensation provided in ORC Section 3501.12, and not to health insurance provided to board of election members pursuant to ORC Section 3501.141, commissioners cannot eliminate health insurance midterm for board of elections members. Any county that considers doing this should first review the nature of the

coverage provided to other officers, such as members of the Veterans Service Commission, and check with the county prosecutor.

67.19 HEALTH CARE COVERAGE FOR MUNICIPAL COURTS

Health care coverage for judges, clerks, and deputy clerks of municipal courts, under certain circumstances, must be provided. Most municipal courts are provided coverage under the county's current medical policy. They are generally covered as any other county or municipal department. Different provisions apply to county operated and non-county operated municipal courts as it relates to which jurisdiction provides coverage and how costs are allocated between the county and municipalities within the jurisdiction of the court. For further information refer to ORC Sections 1901.111 and 1901.312 and Chapter 98 of this *Handbook*.

67.20 HEALTH SAVINGS ACCOUNTS (HSA's) AND HEALTH REIMBURSEMENT ACCOUNTS (HRA's)

HSA's were created by the Medicare Bill signed by President George W. Bush on December 8, 2003 and are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis. HSA's are used in conjunction with a "High Deductible Health Plan" (HDHP). It is insurance that does not cover first dollar medical expenses (except for preventive care) and can be an HMO, PPO or indemnity plan. Any individual can be covered under an HSA as long as they are covered by a HDHP, not covered by any other health insurance, not enrolled in Medicare and cannot be claimed as a dependent on someone else's tax return.

HSA accounts are set up as an individual account at a bank selected by the employee, or at a bank of the employer's choosing if the account is part of an employer sponsored health program. The account is owned by the individual and is portable. If the HSA is a county sponsored health plan, and the employee goes to work at a different employer, the employee owns the account and takes it with them when they leave. If this is a county sponsored plan, any money that the county has contributed to the employee's HSA, belongs to the employee when they leave. The money that is contributed to the HSA by the employee is on a pre-tax basis. As long as the individual uses the money to pay for qualified medical expenses, the money is not taxed. The employee will use the money in the HSA account to pay for the services received, and usually prescription drugs, which are applied to their deductible.

There are guidelines issued by the U.S. Treasury Department concerning several aspects of the HSA's. The first is the maximum amount an individual can contribute into the HSA account for an individual or a family in any given year. The 2013 contribution levels are $3,250 for an individual and $6,450 for a family. There is also a catch up contribution of $1,000 for individuals over the age of 55. There are also maximum out-of-pocket limits under an HSA of $6,250 for an individual and $12,500 for a family. The U.S. Treasury Department has also installed minimum deductibles that are allowed

each year. In 2011 those deductible minimums are $1,250 for an individual and $2,500 for a family.

A HRA is different in the way the account is set up. The HRA is administered through a TPA or through the insurance company. The county first establishes a HDHP with specified deductible limits. Then the county takes a portion of the deductible and pays that portion on claims. For example, if a county HDHP has a $2,000 single deductible and a $4,000 family deductible, the county may choose to fund the first $1,000 of claims for single coverage and the first $2,000 of claims for family coverage for each employee. In this case, after the employee has met the specific claim level of $1,000 for single coverage and $2,000 for family coverage that has been paid by the employer, then the employee pays the rest of the claims until the maximum out-of-pocket has been met.

Under the HRA, the county knows the maximum amount it will be responsible for in any given year for the deductibles. The county maintains an account that the insurer can access, to pay the claims. The account must have a minimum balance in it at all times. The insurer notifies the county on a monthly basis on how much it will remove from the account to pay claims. This way the county controls the money, no money is going into an employee account, and if the employee leaves employment, any money set aside for that employee for the year belongs to the county.

67.21 PUBLIC RECORDS AND HIPPA

While most records maintained by the county are public records under ORC Chapter 149, medical records are specifically exempt under ORC Section 149.43(A)(1). In addition, any private employee records such as social security numbers, dates of birth, or any personal health information that county human resource staff deals with, is protected by HIPPA. These records must be kept under lock and key and under no circumstances should anyone have access to these records that does not have the proper authority.

67.22 SELF-INSURED LIFE INSURANCE

ORC Section 9.833 (C)(10) authorizes that a political subdivision to purchase group life insurance for its employees in conjunction with an individual or joint self-insurance program, provided that the policy of group life insurance is not self-insured. This means that a joint self-insurance pool can purchase group life insurance for its members, but it needs to be an insurance product that is not self-insured.

67.23 COLLECTIVE BARGAINING AGREEMENTS

Counties that purchase insurance coverage for their union employees must adhere to the contracts that are currently in place for their specific unions. Agreements may state that the county has to pay a certain percentage of the health insurance, benefits have to be set at a certain level or prescription drug co-pays must be at a certain level. These

issues must be agreed upon at contract time, and both parties have to agree on the percentages or levels of benefits.

67.24 SPOUSAL COVERAGE AND PAYMENT FOR BENEFITS

There is a trend in the industry to provide coverage for the employee, but if the employee's spouse has a full time position, the spouse must sign up for coverage with their employer. Dependents are usually put on a plan under the "birthday rule". Under this rule, the parent with the earliest birth date, is the plan to which dependents are assigned. This practice reduces the cost to the county.